SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing	SERFF Tr Num: STLG-126337628	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 44114
Sub-TOI: MS08I.001 Plan A 2010	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Authors: Jennifer Marinas, Mary Garcia, Stacey Nguyen, Andrea Callahan, Travis Schultz	Disposition Date: 01/04/2010
	Date Submitted: 11/17/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 06/01/2010		Implementation Date: 06/01/2010

State Filing Description:

General Information

Project Name: 2010 MIPPA Form/Rate Refiling	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 01/04/2010	Explanation for Other Group Market Type:
	State Status Changed: 01/04/2010
Deemer Date:	Created By: Andrea Callahan
Submitted By: Mary Garcia	Corresponding Filing Tracking Number:

Filing Description:

Re: Sterling Life Insurance Company Medicare Select and Standard Medicare Supplement Insurance Filing: FORMS/Rates

NAIC # 77399

NAIC Group #361

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Forms and Actuarial Memorandums for the following policies:

Standard Medicare Supplement

Medicare Supplement Plan A – Form Number: AR STD A (05/10) – Replaces: AR STD A (05/05)
Medicare Supplement Plan B – Form Number: AR STD B (05/10) – Replaces: AR STD B (05/05)
Medicare Supplement Plan C – Form Number: AR STD C (05/10) – Replaces: AR STD C (05/05)
Medicare Supplement Plan F – Form Number: AR STD F (05/10) – Replaces: AR STD F (05/05)
Medicare Supplement Plan G – Form Number: AR STD G (05/10) – Replaces: AR STD G
Medicare Supplement Plan K – Form Number: AR STD K (05/10) – Replaces: AR STD K
Medicare Supplement Plan N – Form Number: AR STD N – Replaces: N/A

SELECT Medicare Supplement

Medicare Select Plan A – Form Number: AR SEL A (05/10) – Replaces: AR SEL A (05/05)
Medicare Select Plan B – Form Number: AR SEL B (05/10) – Replaces: AR SEL B (05/05)
Medicare Select Plan C – Form Number: AR SEL C (05/10) – Replaces: AR SEL C (05/05)
Medicare Select Plan F – Form Number: AR SEL F (05/10) – Replaces: AR SEL F (05/05)
Medicare Select Plan G – Form Number: AR SEL G (05/10) – Replaces: AR SEL G
Medicare Select Plan K – Form Number: AR SEL K (05/10) – Replaces: AR SEL K
Medicare Select Plan N – Form Number: AR SEL N – Replaces: N/A

State Specific Forms Related to the Above Policies
Outline of Coverage – Form Number: AR OC (05/10) with [(Rev. 09/09)] in the right hand corner – Replaces: AR OC (01/09) with [(Rev. 10/08)] in the right hand corner
Application – Form Number: APP 2010 – AR – Replaces: APP 2006 - AR (04/07)

Generic Forms Related to the Above Policies
Notice to Applicant – Form Number: NTA (Rev 09/09) – Replaces: NTA 5/05
Medicare SELECT Disclosure – Form Number: SEL DIS (Rev 09/09) – Replaces: DIS2000 (Rev 05/03)
Medicare SELECT Acknowledgement – Form Number: SEL DIS ACK (Rev 09/09) – Replaces: ACK 1/99

We are filing the above revised forms for your consideration and approval. As required, we are filing all of the Standard Medicare Supplement forms together on this one SERFF filing for Standard Plan A, however all forms attached to this filing are for all policies listed above.With the exception of Plan N, These forms were originally approved by the Department, but have been revised to reflect changes in State and Federal law arising from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), with an effective date of June 1, 2010. This form filing reflects the

following changes mandated by this law and model regulation, as indicated.

The actuarial memorandum included in this filing is intended to comply with the new MIPPA standards for all policies effective on or after June 1, 2010. This rate filing is not intended to be used for other purposes. Attached Exhibit I fully describes the rating areas for this filing by county.

Policies
The following changes were made to all of the policies:

DEFINITIONS
The following definitions were added: (All Plans)

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Hospice
You must meet Medicare's requirement, including a doctor's certification of terminal illness.

Provider
is the general term We use for physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

The following definition was added: (All Select Plans and Standard Plans C, F, G, K)
Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

The following definition was modified: (All Plans)
Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. “Physician” does not include You or any of Your immediate family members.

BASIC BENEFITS
This section was modified: (Standard Plan ONLY)
We will pay as follows:

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept Our payment as payment in full and may not bill You for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

Description #6 of this section was added: (Plans A, B, C, F, and G ONLY)
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

ADDITIONAL BENEFITS
Description #5 of this section was removed: (Plan G ONLY)

5. At Home Recovery:
Coverage for services for short term, at-home assistance with activities of daily living if You are recovering from an illness, injury or surgery and your attending physician has certified the specific type and frequency of at-home recovery

services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

Coverage under this section is limited to:

a) no more than the number and type of at-home recovery visits certified as necessary by Your attending physician. The total number of at-home visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;
b) the actual charges for each visit up to a maximum reimbursement of forty ($40) dollars per visit;
c) one thousand six hundred ($1,600) dollars per calendar year;
d) seven (7) visits in any one week;
e) care furnished on a visiting basis in Your home;
f) services provided by a care provider as defined herein;
g) at-home recovery visits while You are covered under the policy and not otherwise excluded;
h) at-home recovery visits received during the period You are receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

Coverage under this section shall exclude:

a) home care visits paid for by Medicare or other government programs;
b) care provided by family members, unpaid volunteers or providers who are not care providers.

The below sections were modified as follows: (All SELECT Plans ONLY)

CONVERSION PRIVILEGE

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P.O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: “This is a grievance”, or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be mailed within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

The below section was modified as follows: (All Plans)

CLAIM FORMS

When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

The below section was modified as follows: (All Standard Plans)

PROOFS OF LOSS

If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

The below sections were modified as follows: (All Plans)

TIME OF PAYMENT OF CLAIMS

Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS

All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Application – Form Number “APP 2010 - AR”

Besides the addition of Plan N, the only changes to this form were the form number, bracketing the phone numbers, address.

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
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Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Outline of Coverage – Form Number “AR OC (05/10)”
We have made numerous changes to this document. The main changes were in accordance with Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Notice to Applicant Regarding Replacement – Form Number “NTA (Rev 09/09)”
The only changes to this notice were the form number, bracketing the phone numbers and address.

Medicare SELECT Disclosure – Form Number: SEL DIS (Rev 09/09)
The only changes to this disclosure were the form number, bracketing the phone numbers and address, plus the Conversion Privilege was modified to match the provision changed in the policies.

Medicare SELECT Disclosure Acknowledgement – Form Number: SEL DIS ACK (Rev 09/09)
The only changes to this disclosure were the form number, bracketing the phone numbers and address.

These are revised forms intended to replace the currently used forms in Arkansas. These revised forms have been filed for approval in Illinois, Sterling's state of domicile.

If you have any questions, please do not hesitate to contact me at (360) 392-9201 or email jennifer.marinas@sterlingplans.com.

Sincerely,

Jennifer Marinas
Legal Assistant
Compliance & Regulatory Affairs

Company and Contact

Filing Contact Information

Jennifer Marinas, Legal Assistant
2219 Rimland Drive
P.O. Box 5348
Bellingham, WA 98227

jennifer.marinas@sterlingplans.com
360-392-9201 [Phone]
360-647-8632 [FAX]

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
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Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Filing Company Information

Sterling Life Insurance Company	CoCode: 77399	State of Domicile: Illinois
P.O. Box 5348	Group Code: 361	Company Type: Insurance Company - Life, Accident & Health
Bellingham, WA 98227	Group Name:	State ID Number:
(360) 647-9080 ext. [Phone]	FEIN Number: 13-1867829	

Filing Fees

Fee Required?	Yes
Fee Amount:	$950.00
Retaliatory?	Yes
Fee Explanation:	Our state of domicile no longer requires fees. Therefore I am submitting fees set forth by the Arkansas Department of Insurance. These fees are $50 for each policy including all forms associated with the policy and filed with the policy. Other forms filed separately are $20 for each form. There are, in total, 19 forms being submitted at this time.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Life Insurance Company	$950.00	11/17/2009	32107732

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/04/2010	01/04/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Notice to Applicant Regarding Replacement	Andrea Callahan	12/10/2009	12/10/2009
Form	Medicare Supplement and Select Application	Mary Garcia	11/18/2009	11/18/2009

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Disposition

Disposition Date: 01/04/2010
Implementation Date: 06/01/2010
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
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Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage		Yes
Form	Medicare Select Disclosure Statement	Approved	Yes
Form	Medicare Select Acknowledgement of Disclosure	Approved	Yes
Form *(revised)*	Notice to Applicant Regarding Replacement	Approved	Yes
Form	Notice to Applicant Regarding Replacement	Replaced	Yes
Form *(revised)*	Medicare Supplement and Select Application	Approved	Yes
Form	Medicare Supplement and Select Application	Replaced	Yes
Form	Medicare Supplement and Select Outline of Coverage	Approved	Yes
Form	Medicare Supplement Standard Policy Plan A	Approved	Yes
Form	Medicare Supplement Standard Policy Plan B	Approved	Yes
Form	Medicare Supplement Standard Policy Plan C	Approved	Yes
Form	Medicare Supplement Standard Policy Plan F	Approved	Yes
Form	Medicare Supplement Standard Policy Plan G	Approved	Yes
Form	Medicare Supplement Standard Policy Plan K	Approved	Yes
Form	Medicare Supplement Standard Policy Plan N	Approved	Yes
Form	Medicare Supplement Select Policy Plan A	Approved	Yes
Form	Medicare Supplement Select Policy Plan		

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
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Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

	B	Approved	Yes
Form	Medicare Supplement Select Policy Plan C	Approved	Yes
Form	Medicare Supplement Select Policy Plan F	Approved	Yes
Form	Medicare Supplement Select Policy Plan G	Approved	Yes
Form	Medicare Supplement Select Policy Plan K	Approved	Yes
Form	Medicare Supplement Select Policy Plan N	Approved	Yes
Rate	Standard Actuarial Memorandum and Exhibits	Approved	No
Rate	Select Actuarial Memorandum and Exhibits	Approved	No

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
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Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Amendment Letter

Submitted Date: 12/10/2009

Comments:

Please be advised the incorrect Notice to Applicant, Form No. NTA (Rev 09/09), was inadvertently submitted. The correct version is now attached under the Form Schedule.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
NTA (Rev 09/09)	Other	Notice to Applicant Regarding Replacement	Revised			NTA 5/05	0.000	NTA (Rev 09 09).pdf

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Amendment Letter

Submitted Date: 11/18/2009

Comments:

The application has been modified to include brackets around our address. This was the only change made to the application.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
APP 2010 - AR	Application/Enrollment Form	Medicare Supplement and Select Application	Revised			APP 2006 - AR (04/07)	0.000	APP 2010 - AR2.pdf

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/04/2010	SEL DIS (Rev 09/09)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Medicare Select Disclosure Statement	Revised	Replaced Form #: DIS2000 (Rev 05/03) Previous Filing #:	0.000	SEL DIS (Rev 09.09) REVISED.pdf
Approved 01/04/2010	SEL DIS ACK (Rev 09/09)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Medicare Select Acknowledgement of Disclosure	Revised	Replaced Form #: ACK1/99 Previous Filing #:	0.000	SEL DIS ACK (Rev 09.09).pdf
Approved 01/04/2010	NTA (Rev 09/09)	Other	Notice to Applicant Regarding Replacement	Revised	Replaced Form #: NTA 5/05 Previous Filing #:	0.000	NTA (Rev 09 09).pdf
Approved 01/04/2010	APP 2010 - AR	Application/ Enrollment Form	Medicare Supplement and Select Application	Revised	Replaced Form #: APP 2006 - AR (04/07) Previous Filing #:	0.000	APP 2010 - AR2.pdf
Approved 01/04/2010	AR OC (05/10)	Outline of Coverage	Medicare Supplement and Select Outline of Coverage	Revised	Replaced Form #: AR OC (01/09) Previous Filing #:	0.000	AR 2010 OC (Rev. 09.09).pdf
Approved	AR STD A	Policy/Cont	Medicare	Revised	Replaced Form #:	0.000	AR STD A -

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*		
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Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*				

01/04/2010	(05/10)	ract/Fraternal Certificate	Supplement Standard Policy Plan A		AR STD A (05/05) Previous Filing #:		2010.pdf
Approved 01/04/2010	AR STD B (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Standard Policy Plan B	Revised	Replaced Form #: AR STD B (05/05) Previous Filing #:	0.000	AR STD B - 2010.pdf
Approved 01/04/2010	AR STD C (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Standard Policy Plan C	Revised	Replaced Form #: AR STD C (05/05) Previous Filing #:	0.000	AR STD C - 2010.pdf
Approved 01/04/2010	AR STD F (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Standard Policy Plan F	Revised	Replaced Form #: AR STD F (05/05) Previous Filing #:	0.000	AR STD F - 2010.pdf
Approved 01/04/2010	AR STD G (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Standard Policy Plan G	Revised	Replaced Form #: AR STD G Previous Filing #:	0.000	AR STD G - 2010.pdf
Approved 01/04/2010	AR STD K (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Standard Policy Plan K	Revised	Replaced Form #: AR STD K Previous Filing #:	0.000	AR STD K - 2010.pdf
Approved 01/04/2010	AR STD N	Policy/Contract/Fraternal Certificate	Medicare Supplement Standard Policy Plan N	Initial		0.000	AR STD N - 2010.pdf
Approved 01/04/2010	AR SEL A (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Select Policy Plan A	Revised	Replaced Form #: AR SEL A (05/05) Previous Filing #:	0.000	AR SEL A - 2010.pdf
Approved 01/04/2010	AR SEL B (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Select Policy Plan B	Revised	Replaced Form #: AR SEL B (05/05) Previous Filing #:	0.000	AR SEL B - 2010.pdf
Approved 01/04/2010	AR SEL C (05/10)	Policy/Contract/Fraternal	Medicare Supplement Select	Revised	Replaced Form #: AR SEL C (05/05)	0.000	AR SEL C - 2010.pdf

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

		al Certificate	Policy Plan C		Previous Filing #:		
Approved 01/04/2010	AR SEL F (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Select Policy Plan F	Revised	Replaced Form #: AR SEL F (05/05) Previous Filing #:	0.000	AR SEL F - 2010.pdf
Approved 01/04/2010	AR SEL G (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Select Policy Plan G	Revised	Replaced Form #: AR SEL G Previous Filing #:	0.000	AR SEL G - 2010.pdf
Approved 01/04/2010	AR SEL K (05/10)	Policy/Contract/Fraternal Certificate	Medicare Supplement Select Policy Plan K	Revised	Replaced Form #: AR SEL K Previous Filing #:	0.000	AR SEL K - 2010.pdf
Approved 01/04/2010	AR SEL N	Policy/Contract/Fraternal Certificate	Medicare Supplement Select Policy Plan N	Initial		0.000	AR SEL N - 2010.pdf

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service

[P.O. Box 5348, Bellingham, WA 98227-5348]

[(800) 688-0010]

Medicare SELECT Disclosure Statement

NETWORK HOSPITAL RESTRICTIONS

Except as specified below, Part A and Part B (hospital or facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital or facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;
2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;
3. While Traveling outside the Service Area, services will be covered from the 1st day through the ninety (90)th day of each trip, travel must be for purposes other than the receipt of medical care; or
4. Required services are not available at a Network Hospital in Your Service Area.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

Network Hospitals

A Network Hospital is one that has a written agreement with Sterling and has been designated by Sterling to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, you, either directly or through your physician, should contact Sterling's Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist you in locating a hospital that provides the necessary service. **Utilizing Sterling's Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations, while you are traveling outside of the service area. Travel must be for purposes other than the receipt of medical care.

Your Right to Purchase a Non-Restrictive Plan

Conversion Privilege

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

Non-restrictive plans generally cost more than SELECT plans, which contain restrictions on your use of hospital. For complete details, please see your Sterling agent.

Quality Assurance

When you purchase a Sterling Medicare SELECT plan, you agree to use a Sterling Network Hospital whenever possible.

Our goal is to ensure access to high quality health care, and we are continually striving to improve our services. To achieve this goal, our Quality Assurance Program allows us to monitor and evaluate the quality of care received by our policyholders. In addition, Sterling requires Network Hospitals to meet or exceed acceptable standards of quality care for their field, and to maintain a quality assurance program that conforms with local and nationally-recognized quality of care standards.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, we will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P.O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Written acknowledgment of receipt of the grievance will be mailed within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P.O. Box 5348, Bellingham, WA 98227-5348]
[1-800 688-0010]

Acknowledgment of Receipt of Medicare SELECT Disclosure Statement

I, the applicant, acknowledge receipt of the following information:

☐ Outline of Coverage and Premium Information for the Medicare SELECT Plan for which I am applying;

☐ Description of Network Hospitals; and

☐ Medicare SELECT Disclosure Statement.

I also understand the following:

☐ The Part A and Part B benefits of Sterling's Medicare SELECT plan may not be paid if I receive services in a hospital that is not a Network Hospital.

☐ Sterling Life Insurance Company does not advise the purchase of a Medicare SELECT policy if I live more than 30 minutes from the Network Hospital; unless the Network Hospital is the closest hospital to me which offers this level of service.

☐ My physician must have admitting privileges at a Network Hospital; or should be willing to refer me to a physician who does in the event I require hospitalization.

☐ I have the right to purchase any non-restricted Medicare supplement insurance product, offered by Sterling Life Insurance Company.

I acknowledge receipt and understanding of the information above.

_____ _____

Signature Date

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
P.O. Box 5348, Bellingham, WA 98227-5348
(800) 688-0010

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Sterling. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:
I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s): (Check one):

- ☐ Additional benefits.
- ☐ No change in benefits but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:

_____

- ☐ Other, please specify: _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
(Signature of Agent, Broker or Other Representative) (Date)

_____
(Typed name and address of Issuer, Agent or Broker)

_____ _____
(Applicant's Signature) (Date)

Sterling Life Insurance Company
Application for Medicare Supplement Insurance

[P.O. Box 5348 ~ Bellingham, WA 98227 ~ 800/688-0010]

1. Applicant Information

Insured's Name (as it appears on Medicare Card) _____
LAST FIRST MI

Medicare ID # _____ Social Security # _____

☐ Yes, I am insured under Medicare Part A and B / Part B Effective Date _____

Physical Address _____ Phone Number _____

City _____ County _____ State _____ Zip _____

Mailing Address _____

City _____ County _____ State _____ Zip _____

Age (at Requested Effective Date) _____ Date of Birth ___ / ___ / ___ Gender ☐ M ☐ F

2. Requested Effective Date ___ / ___ / ___

3. Medicare Supplement Coverage Options

Standard: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan K ☐ Plan N

SELECT: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan K ☐ Plan N

4. Payment Options

Monthly: ☐ Coupons ☐ Automatic Bank Draft

Statement: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Premium Amount Collected
$_____

5. Power of Attorney/Guardian

Have you authorized any person to legally act on your behalf and take over your personal business transactions (POA, Guardian, etc.)? ☐ Yes ☐ No

If Yes, Name (Please include documentation) _____

Address _____ City _____ State _____ Zip _____

Should all mailings go to POA, Guardian, etc. at this address? ☐ Yes ☐ No

IF YOU LOST OR ARE LOSING OTHER HEALTH INSURANCE COVERAGE AND RECEIVED A NOTICE FROM YOUR PRIOR INSURER SAYING YOU WERE ELIGIBLE FOR GUARANTEED ISSUE OF A MEDICARE SUPPLEMENT INSURANCE POLICY, OR THAT YOU HAD CERTAIN RIGHTS TO BUY SUCH A POLICY, YOU MAY BE GUARANTEED ACCEPTANCE IN ONE OR MORE OF OUR MEDICARE SUPPLEMENT PLANS. PLEASE INCLUDE A COPY OF THE NOTICE FROM YOUR PRIOR INSURER WITH YOUR APPLICATION.

PLEASE ANSWER ALL QUESTIONS. To the best of your knowledge:

6. (a) Did you turn age 65 in the last 6 months?: ☐ Yes ☐ No

(b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

(c) If yes, what is the effective date of Part B? ____/___/_____

7. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.

If Yes,

(a) Will Medicaid pay your premium for this Medicare supplement policy? ☐ Yes ☐ No

(b) Do you received any benefits from Medicaid OTHER THAN payments

toward your Medicare Part B premium? ☐ Yes ☐ No

8. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END___/___/____

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No

(c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

(d) Did you cancel a Medicare supplement policy prior to enrolling in this Medicare plan? ☐ Yes ☐ No

9. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

(b) If so, with what company, and what plan do you have? _____

(c) If so, so you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

10. Have you had any coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)?) ☐ Yes ☐ No

(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START ___/__/___ END ___/__/_____

I UNDERSTAND IT IS MY OBLIGATION AND RESPONSIBILITY TO DISENROLL MYSELF FROM MY PRESENT MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE PROGRAM. NEITHER THE AGENT NOR THE INSURANCE COMPANY HAS THE AUTHORITY TO DISENROLL ME FROM THE PROGRAM.

Applicant's Signature _____

****If you are applying during an open enrollment or guaranteed issue period, you do not have to answer Health Questions 11 or 12.**

11. If any of the following questions are answered "Yes" the applicant is uninsurable.

A. Within the past two years, have you received any medical advice or treatment by a member of the medical profession, or been hospitalized for any of the following:

1. Stroke, heart attack, coronary artery disease including angina, arteriosclerosis or artherosclerosis or congestive heart failure? ☐ Yes ☐ No
2. Cancer (excluding skin), Leukemia, Hodgkins' Disease or Melanoma? ☐ Yes ☐ No
3. Alzheimer's Disease, Parkinson's Disease, Lou Gehrig's Disease or ALS, Multiple Sclerosis or Muscular Dystrophy? ☐ Yes ☐ No
4. Chronic Obstructive Lung / Pulmonary Disease or Emphysema? ☐ Yes ☐ No
5. Alcoholism, Drug Addiction, Cirrhosis of the Liver or Renal Failure? ☐ Yes ☐ No
6. Insulin Dependent Diabetes or Rheumatoid or Disabling Arthritis? ☐ Yes ☐ No
7. Have you required oxygen therapy, kidney dialysis, a defibrillator, bypass surgery, angioplasty, pacemaker or stent placement? ☐ Yes ☐ No

B. Have you been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive

for HIV virus? ☐ Yes ☐ No

12. Within the past two years, have you been confined to or utilized: a hospital, skilled nursing facility, nursing home, ambulatory surgery center or another similar facility?
If "Yes", please explain below: ☐ Yes ☐ No

Condition	Onset Date	Operation Date	Recovery Date	Days in Hospital	Days in Nursing Facility

A. Please indicate your height and weight: _____ Ft. _____ In. / _____ Lbs.

B. Have you used tobacco products in the last two years? ☐ Yes ☐ No

13. Acknowledgments. The Applicant, to the best of his / her knowledge and belief, represents and agrees as follows:

A. You do not need more than one Medicare Supplement Policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

B. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy

C. If, after purchasing this policy, you become eligible for Medicaid, benefits and premiums under the Medicare Supplement policy will be suspended during entitlement to benefits under Medicaid for 24 months, as long as suspension is requested within 90 days of becoming eligible for Medicaid. When you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.

D. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while your are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

E. Counseling services may be available in your state to provide advice concerning the purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

F. That the statements contained in the application concerning past and present health conditions are complete, true and correct.

G. No agent or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.

H. Insurance issued as a result of this application will take effect as specified in the Conditional Receipt.

I. Plan provisions concerning exceptions, exclusions, limitations and renewal which have been applied for have been explained and understood.

J. The Applicant acknowledges receipt of the **Outline of Coverage** and the **Guide to Health Insurance for People with Medicare.**

14. **Representation**. The undersigned applicant and agent acknowledge that the applicant has read or has had read to him / her the completed application and that he / she realizes that any false statements or misrepresentation therein may result in loss of coverage under the policy.

15. **Payment of Premium**. Read the Conditional Receipt before signing this Application. This is to acknowledge that I have read the Receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of the Conditional Receipt.

16. **Release**. In connection with an application for insurance currently made to Sterling, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization shall be valid for a period of two years and six months from the date signed.

17. **Release for claims processing**. I further authorize Sterling, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Centers for Medicare and Medicaid Services (CMS), or its duly appointed Part A intermediaries or Part B carriers to release to Sterling information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include EOMBs, "deduct-not-met" or denial letter, Part B billing forms, and information date of enrollment in Part B of Medicare. I further authorize ongoing release of this information to Sterling for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Sterling in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, that I will need to fill out claims forms and some records could be released before the rescission has time to take effect.

Dated at City _____ State _____ Zip _____

Applicant's Signature _____ Date _____

Agent: List all policies you have sold to the applicant, including those no longer in force, if sold in the last five years (if none, state "none"):

Policies sold which are still in force: _____

_____

Policies sold in the past five years which are no longer in force:_____

_____

Agent Witness. I have witnessed the signature of the Applicant. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for ☐ is or is likely; ☐ is not or is not likely to replace or change any existing policy (ies) or contract(s).

Signature of Licensed Agent _____ Agent # _____

Print Name _____ Office ID _____

NOTICE. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate State Agency.

For Administrative Purposes Only:

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service [P.O. Box 5348, Bellingham, WA 98227-5348]

Outline of Medicare Supplement Coverage - Cover Page 1 of 2

Benefit Chart of Medicare Supplement Plans Sold with Effective Dates on or after June 1, 2010

Standard Medicare Supplement Plans A, B, C, F, K and N are Available.
[Plans E, H, I, and J are no longer available for sale after June 1, 2010.]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in Your state. **The starred (*) plans (A, B, C, F, G, K, N) are also available as Medicare SELECT Plans. Medicare SELECT plans contain restrictions on your use of providers.**

See Outlines of Coverage sections for details about ALL plans

BASIC BENEFITS for Plans A-N

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice –** Part A cost sharing.

*A	*B	*C	D	*F	F*	Innovative F	*G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		+Basic Benefits	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible		Part B Deductible	
				Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency
						+Innovative Benefits+	

***Plan F** also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plans F after one has paid a calendar year $[2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $[2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

+Innovative F includes innovative benefits not contained in other standardized Medicare Supplement Plans. They include, subject to plan limitations: (a) access to nurse advice telephone service, (b) annual physical examination, (c) preventive dental care, (d) routing vision care, and (e) routine hearing exam.

The starred (*) plans (A, B, C, F, G, K, N) are also available as Medicare SELECT Plans. Medicare SELECT plans contain restrictions on your use of providers.

STERLING LIFE INSURANCE COMPANY

Outline of Medicare Supplement Coverage - Cover Page 2

Basic Benefits for Plans K and L include <u>similar</u> services as Plans A-G, but cost sharing for the basic benefits are at different levels.

*K**	L**	M	*N
Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4,620]; benefits paid at 100% after limit reached	Out-of -pocket limit $[2,310]; benefits paid at 100% after limit reached		

****Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges. The out-of-pocket annual limit will increase each year for inflation.**

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION

Sterling Life Insurance Company may raise Your premium if it raises the premium for all policies in Your class. Premiums are community rated and based on the mode of the premium payment selected. **Premium in the chart below is subject to change.**

[(INSERT PAGES -3 – 3B)]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE DISCLOSURES

DISCLOSURES Use this outline to compare benefits and premiums among policies. [This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I and J are no longer available for sale after June 1, 2010.]

READ YOUR POLICY VERY CAREFULLY This is only an outline describing Your policy's most important features. The policy is Your insurance contract. You must read the policy itself to understand all of the rights and duties of both You and Your insurance company.

RIGHT TO RETURN POLICY If You are not satisfied with Your policy, You may return it to us within thirty (30) days after You receive it. You may return it to us or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

POLICY REPLACEMENT If You are replacing another health insurance policy, do NOT cancel it until You have actually received Your new policy and are sure You want to keep it.

NOTICE This policy may not fully cover all of Your medical costs. Neither Sterling Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact Your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before You sign it. Be certain that all information has been properly recorded.

REFUND OF PREMIUM

If termination is due to You ceasing to be eligible for this plan or We receive written notice that You wish to terminate Your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

LIMITATIONS AND EXCLUSIONS

Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

NETWORK HOSPITAL RESTRICTIONS – MEDICARE SELECT PRODUCTS ONLY

Except as specified below, Part A and Part B (hospital or facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital or facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services. Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;

2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;

3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or

4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Sterling and has been designated by Sterling to provide hospital services to insured under this policy. You may use any Network Hospital, which is listed, on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of [5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Sterling's Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Sterling's Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. Travel must be for purposes other than the receipt of medical care.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued for whatever reason or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE – MEDICARE SELECT PRODUCTS ONLY

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE – MEDICARE SELECT PRODUCTS ONLY

Complaints While Staying At A Network Hospital.
If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, we will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE – MEDICARE SELECT PRODUCTS ONLY

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P.O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Written acknowledgment of receipt of the grievance will be mailed within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 West Third Street, Little Rock, AR 72201-1904 or call 1-800-852-5494 or (501) 371-2640].

PLAN A - BENEFITS CHART

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,100]	$0	$[1,100] (Part A Deductible)
61st thru 90th day	All but $[275] a day	$[275] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[550] a day	$[550] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days (**See your policy, page 5 or 6 for details of coverage.**)	$0	100% of Medicare Eligible Expenses	$0 See NOTICE below
-Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[137.50] a day	$0	Up to $[137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN B - BENEFITS CHART

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,100]	$[1,100] (Part A Deductible)	$0
61st thru 90th day	All but $[275] a day	$[275] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[550] a day	$[550] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ⩛See NOTICE below
(⩛**See your policy, page 5 or 6 for details of coverage**.)			
-Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[137.50] a day	$0	Up to $[137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN C - BENEFITS CHART

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,100]	$[1,100] (Part A Deductible)	$0
61st thru 90th day	All but $[275] a day	$[275] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[550] a day	$[550] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ↘See NOTICE below
(↘**See your policy, page 5 or 6 for details of coverage**.)			
-Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[137.50] a day	Up to $[137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$[155] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[155] of Medicare-Approved Amounts*	$0	$[155] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$[155] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$0	$0	$250
Remainder of Charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 Lifetime Maximum Benefit

PLAN F - BENEFITS CHART

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,100]	$[1,100] (Part A Deductible)	$0
61st thru 90th day	All but $[275] a day	$[275] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[550] a day	$[550] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ↘See NOTICE below
(↘**See your policy, page 5 or 6 for details of coverage**.)			
-Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[137.50] a day	Up to $[137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$[155] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $[155] of Medicare-Approved Amounts*	$0	$[155] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$[155] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$0	$0	$250
Remainder of Charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 Lifetime Maximum Benefit

PLAN G - BENEFITS CHART

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,100]	$[1,100] (Part A Deductible)	$0
61st thru 90th day	All but $[275] a day	$[275] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[550] a day	$[550] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ↘See NOTICE below
(↘**See your policy, page 5 or 6 for details of coverage**.)			
-Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[137.50] a day	Up to $[137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirement, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare cost sharing	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80% Generally	20% Generally	$0
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$0	$0	$250
Remainder of Charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 Lifetime Maximum Benefit

PLAN K - BENEFITS CHART

You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[4,620] each calendar year. The amounts that count toward your annual limit are noted with the diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. ** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,100]	$[550] (50% of Part A Deductible)	$[550] (50% of Part A Deductible)◆
61st thru 90th day	All but $[275] a day	$[275] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[550] a day	$[550] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ⩛See NOTICE below
(⩛**See your policy, page 5 or 6 for details of coverage**.)			
-Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[137.50] a day	Up to $[68.75] a day	Up to $[68.75] a day◆
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%◆
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of cost sharing	50% of cost sharing ◆

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)*◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare-Approved amounts	Remainder of Medicare-Approved amounts	All costs above Medicare-Approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[4,620])***
BLOOD			
First 3 pints	$0	50%	50%◆
Next $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)*◆
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $[155] of Medicare-Approved Amounts****	$0	$0	$[155] (Part B Deductible)*◆
Remainder of Medicare-Approved Amounts	80%	10%	10%◆

***__This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4,620] per year.__ However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People With Medicare*.

PLAN N - BENEFITS CHART

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,100]	$[1,100] (Part A Deductible)	$0
61st thru 90th day	All but $[275] a day	$[275] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[550] a day	$[550] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ↘See NOTICE below
(↘**See your policy, page 5 or 6 for details of coverage**.)			
-Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[137.50] a day	Up to $[137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** **$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80% Generally	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	$Up to $20 per office visit and up to $50 per emergency visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency room visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $[155] of Medicare-Approved Amounts*	$0	$0	$[155] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

(Continued) PLAN N - BENEFITS CHART

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$0	$0	$250
Remainder of Charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 Lifetime Maximum Benefit

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SUPPLEMENT PLAN A

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

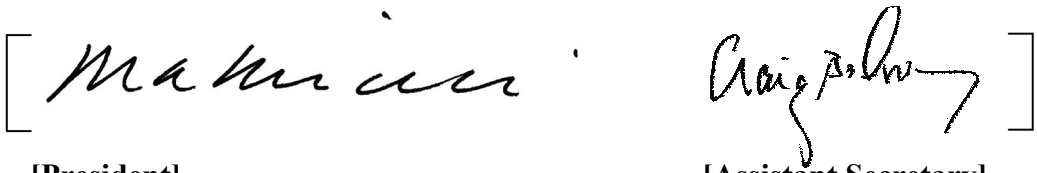
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our President and Secretary.



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or any of Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

We, **Us**, and **Our** r
efers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, copayment amounts, and Part B Calendar Year deductible are determined by Medicare.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred, shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and co-insurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. When You use a Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notifies Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SUPPLEMENT PLAN B

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

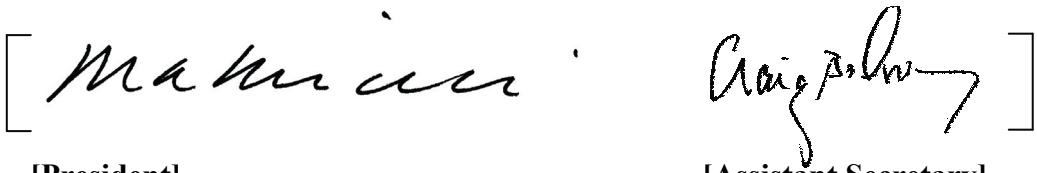
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our President and Secretary.



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or any of Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

We, **Us**, and **Our** r
efers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, copayment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred, shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and co-insurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES
This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. When You use a Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notifies Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SUPPLEMENT PLAN C

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

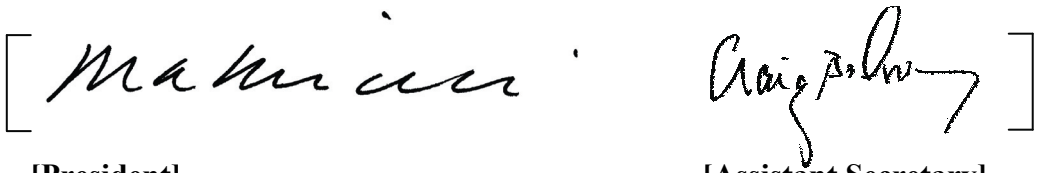
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our President and Secretary.



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or any of Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

We, **Us**, and **Our** r
efers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, copayment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.

4. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or sickness of sudden and unexpected onset.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred, shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and co-insurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. When You use a Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notifies Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
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LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
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MEDICARE SUPPLEMENT PLAN F

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
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You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

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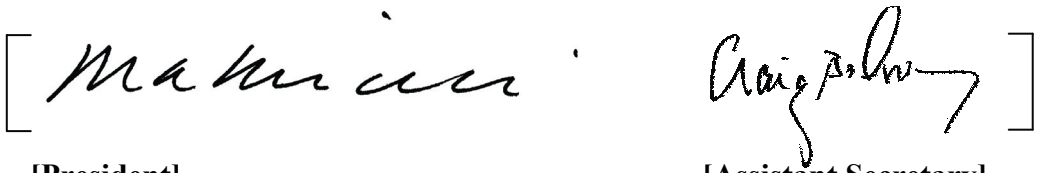
READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our President and Secretary.



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

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TABLE OF CONTENTS

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PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or any of Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

We, **Us**, and **Our** r
efers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, copayment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare Part A.
3. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.
4. One hundred percent (100%) of the Medicare Part B Excess Charges: Coverage for all the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
5. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or sickness of sudden and unexpected onset.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred, shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and co-insurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. When You use a Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare

Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notifies Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SUPPLEMENT PLAN G

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

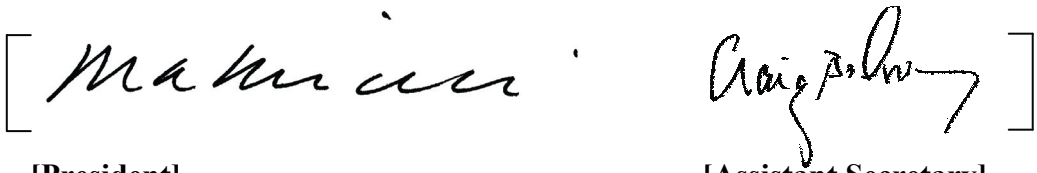
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our President and Secretary.



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or any of Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

We, **Us**, and **Our** r
efers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The Provider shall accept Our payment as payment in full and may not bill You for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, copayment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows:

1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care which follows a three (3) day hospital admission.

3. Medically Necessary Emergency Care in a Foreign Country Coverage to the extent not covered by Medicare for eighty (80%) percent of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty ($250) dollars, and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

4. Coverage for one hundred percent (100%) of the Medicare Part B Excess Charges; or the difference between the actual Medicare Part B charge as billed, not to exceed maximum state or federal billing limitations, and the Medicare approved Part B charge.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred, shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and co-insurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. When You use a Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

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When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

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The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

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No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

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Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notifies Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SUPPLEMENT PLAN K

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

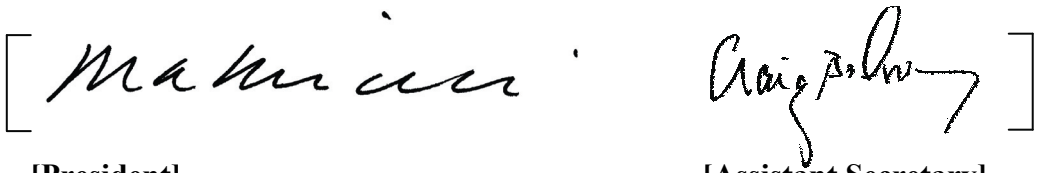
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our President and Secretary.



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or any of Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

We, **Us**, and **Our** r
efers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

PLAN BENEFITS

We will pay as follows:

1. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;
2. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;
4. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Section #10 below;
5. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Section #10 below;
6. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Section #10 below;
7. Coverage for fifty percent (50%) under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Section #10 below;

8. Except for coverage provided in Section #9 below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Section #10 below;
9. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
10. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND
Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred, shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to us.

CHANGES IN MEDICARE COST SHARING AMOUNTS
If Medicare changes its deductible and co-insurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES
This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. When You use a Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notifies Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:

1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims

If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage

If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:

1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SUPPLEMENT PLAN N

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

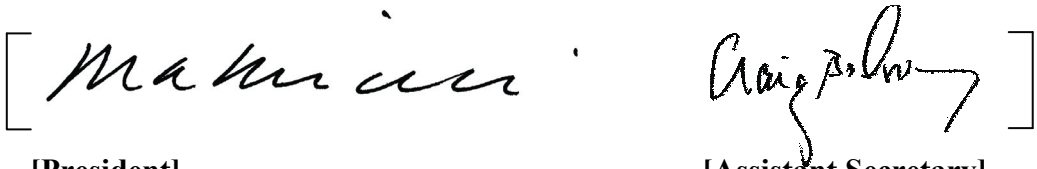
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our President and Secretary.



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily Injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or any of Your immediate family members.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

We, **Us**, and **Our** r
efers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

PLAN BENEFITS

We will pay as follows:

1. Coverage of the Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept Our payment as payment in full and may not bill You for any balance.
4. Coverage under Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed read blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. Coverage for the Medicare Part B coinsurance of Medicare eligible expenses regardless of hospital confinement, other than a co-payment of up to $20 per office visit and up to $50 per emergency room visit, subject to the Medicare Part B deductible. The co-payment is waived if the policyholder is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
7. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
8. Coverage for Medicare eligible expenses up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for skilled nursing facility care.

9. Coverage, to the extent not covered by Medicare, for eighty percent (80%) of the billed charges for Medicare eligible expenses of medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which is begun during the first sixty (60) consecutive days of a trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred, shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and co-insurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD

This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT

If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. When You use a Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Hospital. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notifies Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:

1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims

If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage

If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:

1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SELECT SUPPLEMENT PLAN A

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

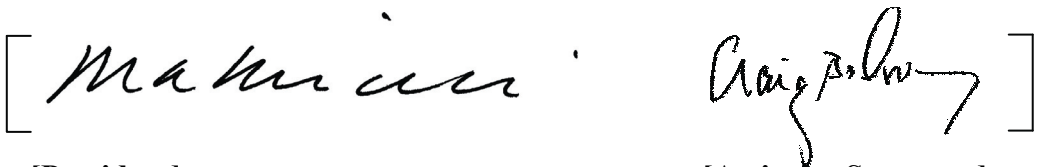
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our [President] and [Assistant Secretary].



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
Both Part A and Part B (Hospital and Facility) benefits described in this policy are restricted if You receive services in a Hospital that is not a Network Hospital. THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

You can convert this policy to a policy which does not contain restricted network provisions. See Conversion Privilege.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare;
2. Enrolled in both Medicare Parts A and B; and
3. A resident in an approved Medicare SELECT Service Area.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Complaint
is any dissatisfaction expressed by an individual concerning a Medicare SELECT Issuer or a Network Hospital.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Grievance
is a dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy with the administration, claims practices, or provision of services concerning a Medicare SELECT Issuer or a Network Hospital.

Hospice
You must meet Medicare's requirement, including a doctor's certification of terminal illness.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare SELECT Issuer
as referred to in this policy, means Sterling Life Insurance Company.

Medicare SELECT Policy
means a Medicare supplement policy that contains restricted network provisions (such as this).

Network Hospital
means a Hospital which has entered into an agreement with Us to provide health care services insured under this policy.

Non-Network Hospital
means a Hospital that has not entered into a written agreement with Us to provide health care services insured under a Medicare SELECT policy.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Restricted Network Provision
is any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

Service Area
is the geographic area approved by a State's Insurance Commissioner within which: (1) We are authorized to offer a Medicare SELECT policy; and (2) Network Hospitals are available.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

Traveling
means leaving the Service Area for purposes other than to receive services from a non-Network Hospital.

We, **Us**, and **Our**
refers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

NETWORK HOSPITAL RESTRICTIONS

Except as specified below, Part A and Part B (Hospital and Facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital and facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;
2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;
3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or
4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Us and has been designated by Us to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Our Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Our Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. (Travel must be for purposes other than the receipt of medical care.)

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The Provider shall accept Our payment as payment in full and may not bill You for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, We will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P. O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be made within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 W. 3rd St., Little Rock, AR 72201-1904 or call 1-800-224-6330].

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to Us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and coinsurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD

This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. Your Network Hospitals will bill us directly. When You use a non-Network Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notify Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions on Page 6 of this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SELECT SUPPLEMENT PLAN B

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

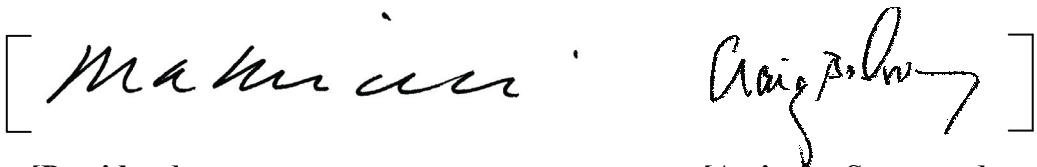
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our [President] and [Assistant Secretary].



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
Both Part A and Part B (Hospital and Facility) benefits described in this policy are restricted if You receive services in a Hospital that is not a Network Hospital. THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

You can convert this policy to a policy which does not contain restricted network provisions. See Conversion Privilege.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare;
2. Enrolled in both Medicare Parts A and B; and
3. A resident in an approved Medicare SELECT Service Area.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Complaint
is any dissatisfaction expressed by an individual concerning a Medicare SELECT Issuer or a Network Hospital.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Grievance
is a dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy with the administration, claims practices, or provision of services concerning a Medicare SELECT Issuer or a Network Hospital.

Hospice
You must meet Medicare's requirement, including a doctor's certification of terminal illness.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare SELECT Issuer
as referred to in this policy, means Sterling Life Insurance Company.

Medicare SELECT Policy
means a Medicare supplement policy that contains restricted network provisions (such as this).

Network Hospital
means a Hospital which has entered into an agreement with Us to provide health care services insured under this policy.

Non-Network Hospital
means a Hospital that has not entered into a written agreement with Us to provide health care services insured under a Medicare SELECT policy.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Restricted Network Provision
is any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

Service Area
is the geographic area approved by a State's Insurance Commissioner within which: (1) We are authorized to offer a Medicare SELECT policy; and (2) Network Hospitals are available.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

Traveling
means leaving the Service Area for purposes other than to receive services from a non-Network Hospital.

We, **Us**, and **Our**
refers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

NETWORK HOSPITAL RESTRICTIONS

Except as specified below, Part A and Part B (Hospital and Facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital and facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;
2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;
3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or
4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Us and has been designated by Us to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Our Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Our Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. (Travel must be for purposes other than the receipt of medical care.)

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The Provider shall accept Our payment as payment in full and may not bill You for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows, subject to the Network Hospital Restrictions:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, We will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P. O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be made within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 W. 3rd St., Little Rock, AR 72201-1904 or call 1-800-224-6330].

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to Us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and coinsurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD

This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. Your Network Hospitals will bill us directly. When You use a non-Network Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notify Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions on Page 6 of this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SELECT SUPPLEMENT PLAN C

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

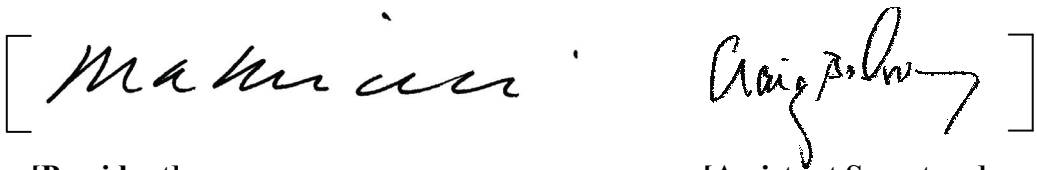
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our [President] and [Assistant Secretary].



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
Both Part A and Part B (Hospital and Facility) benefits described in this policy are restricted if You receive services in a Hospital that is not a Network Hospital. THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

You can convert this policy to a policy which does not contain restricted network provisions. See Conversion Privilege.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare;
2. Enrolled in both Medicare Parts A and B; and
3. A resident in an approved Medicare SELECT Service Area.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Complaint
is any dissatisfaction expressed by an individual concerning a Medicare SELECT Issuer or a Network Hospital.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Grievance
is a dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy with the administration, claims practices, or provision of services concerning a Medicare SELECT Issuer or a Network Hospital.

Hospice
You must meet Medicare's requirement, including a doctor's certification of terminal illness.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare SELECT Issuer
as referred to in this policy, means Sterling Life Insurance Company.

Medicare SELECT Policy
means a Medicare supplement policy that contains restricted network provisions (such as this).

Network Hospital
means a Hospital which has entered into an agreement with Us to provide health care services insured under this policy.

Non-Network Hospital
means a Hospital that has not entered into a written agreement with Us to provide health care services insured under a Medicare SELECT policy.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Restricted Network Provision
is any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

Service Area
is the geographic area approved by a State's Insurance Commissioner within which: (1) We are authorized to offer a Medicare SELECT policy; and (2) Network Hospitals are available.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

Traveling
means leaving the Service Area for purposes other than to receive services from a non-Network Hospital.

We, **Us**, and **Our**
refers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

NETWORK HOSPITAL RESTRICTIONS

Except as specified below, Part A and Part B (Hospital and Facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital and facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;

2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;

3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or

4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Us and has been designated by Us to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Our Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Our Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. (Travel must be for purposes other than the receipt of medical care.)

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The Provider shall accept Our payment as payment in full and may not bill You for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows, subject to the Network Hospital Restrictions:

1. Medicare Part A Deductible:
   Coverage for all of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

2. Skilled Nursing Facility Care:
   Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible:
   Coverage for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.

4. Medically Necessary Emergency Care in a Foreign Country:
   Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, We will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P. O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be made within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 W. 3rd St., Little Rock, AR 72201-1904 or call 1-800-224-6330].

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to Us.

CHANGES IN MEDICARE COST SHARING AMOUNTS
If Medicare changes its deductible and coinsurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES
This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. Your Network Hospitals will bill us directly. When You use a non-Network Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notify Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:

1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions on Page 6 of this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

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MEDICARE SELECT SUPPLEMENT PLAN F

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

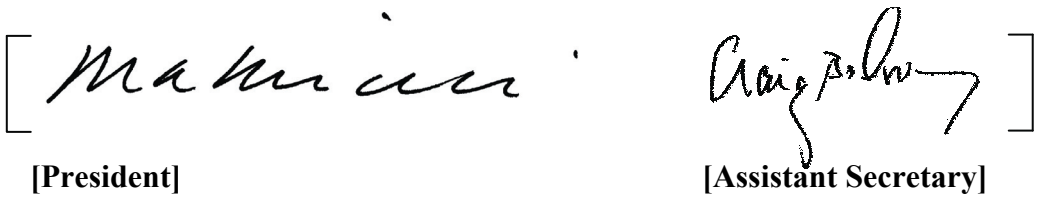
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our [President] and [Assistant Secretary].



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The effective date of insurance for You shall be: «effective_date»

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Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

Traveling
means leaving the Service Area for purposes other than to receive services from a non-Network Hospital.

We, **Us**, and **Our**
refers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

NETWORK HOSPITAL RESTRICTIONS

Except as specified below, Part A and Part B (Hospital and Facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital and facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;

2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;

3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or

4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Us and has been designated by Us to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Our Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Our Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. (Travel must be for purposes other than the receipt of medical care.)

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The Provider shall accept Our payment as payment in full and may not bill You for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows, subject to the Network Hospital Restrictions:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.

4. One hundred percent (100%) of the Medicare Part B Excess Charges: Coverage for all the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, We will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P. O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be made within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 W. 3rd St., Little Rock, AR 72201-1904 or call 1-800-224-6330].

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND

Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to Us.

CHANGES IN MEDICARE COST SHARING AMOUNTS
If Medicare changes its deductible and coinsurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES
This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. Your Network Hospitals will bill us directly. When You use a non-Network Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notify Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:

1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions on Page 6 of this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SELECT SUPPLEMENT PLAN G

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

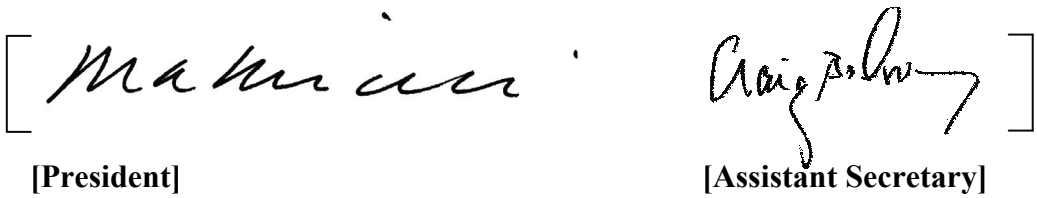
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our [President] and [Assistant Secretary].



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
Both Part A and Part B (Hospital and Facility) benefits described in this policy are restricted if You receive services in a Hospital that is not a Network Hospital. THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

You can convert this policy to a policy which does not contain restricted network provisions. See Conversion Privilege.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare;
2. Enrolled in both Medicare Parts A and B; and
3. A resident in an approved Medicare SELECT Service Area.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Complaint
is any dissatisfaction expressed by an individual concerning a Medicare SELECT Issuer or a Network Hospital.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Grievance
is a dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy with the administration, claims practices, or provision of services concerning a Medicare SELECT Issuer or a Network Hospital.

Hospice
You must meet Medicare's requirement, including a doctor's certification of terminal illness.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare SELECT Issuer
as referred to in this policy, means Sterling Life Insurance Company.

Medicare SELECT Policy
means a Medicare supplement policy that contains restricted network provisions (such as this).

Network Hospital
means a Hospital which has entered into an agreement with Us to provide health care services insured under this policy.

Non-Network Hospital
means a Hospital that has not entered into a written agreement with Us to provide health care services insured under a Medicare SELECT policy.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Restricted Network Provision
is any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

Service Area
is the geographic area approved by a State's Insurance Commissioner within which: (1) We are authorized to offer a Medicare SELECT policy; and (2) Network Hospitals are available.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

Traveling
means leaving the Service Area for purposes other than to receive services from a non-Network Hospital.

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Except as specified below, Part A and Part B (Hospital and Facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital and facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;

2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;

3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or

4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Us and has been designated by Us to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

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Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Our Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Our Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. (Travel must be for purposes other than the receipt of medical care.)

BASIC BENEFITS

We will pay as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The Provider shall accept Our payment as payment in full and may not bill You for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

ADDITIONAL BENEFITS

We will pay as follows:

1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.

2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for skilled nursing facility care, which follows a three (3) day hospital inpatient admission.

3. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or sickness of sudden and unexpected onset.

4. Coverage for one hundred percent (100%) of the Medicare Part B Excess Charges; or the difference between the actual Medicare Part B charge as billed, not to exceed maximum state or federal billing limitations, and the Medicare approved Part B charge.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, We will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P. O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be made within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 W. 3rd St., Little Rock, AR 72201-1904 or call 1-800-224-6330].

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND: Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to Us.

CHANGES IN MEDICARE COST SHARING AMOUNTS
If Medicare changes its deductible and coinsurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES
This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. Your Network Hospitals will bill us directly. When You use a non-Network Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notify Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:

1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions on Page 6 of this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SELECT SUPPLEMENT PLAN K

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

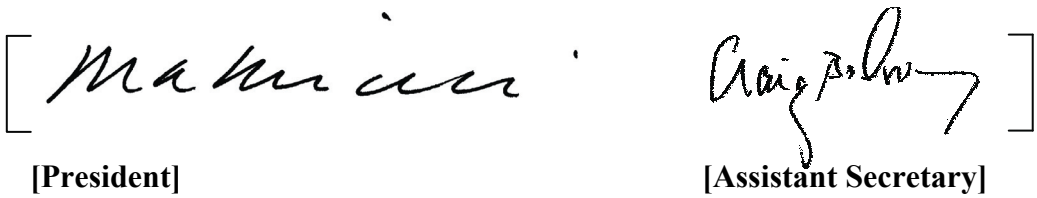
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our [President] and [Assistant Secretary].



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
Both Part A and Part B (Hospital and Facility) benefits described in this policy are restricted if You receive services in a Hospital that is not a Network Hospital. THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

You can convert this policy to a policy which does not contain restricted network provisions. See Conversion Privilege.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare;
2. Enrolled in both Medicare Parts A and B; and
3. A resident in an approved Medicare SELECT Service Area.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Complaint
is any dissatisfaction expressed by an individual concerning a Medicare SELECT Issuer or a Network Hospital.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Grievance
is a dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy with the administration, claims practices, or provision of services concerning a Medicare SELECT Issuer or a Network Hospital.

Hospice
You must meet Medicare's requirement, including a doctor's certification of terminal illness.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare SELECT Issuer
as referred to in this policy, means Sterling Life Insurance Company.

Medicare SELECT Policy
means a Medicare supplement policy that contains restricted network provisions (such as this).

Network Hospital
means a Hospital which has entered into an agreement with Us to provide health care services insured under this policy.

Non-Network Hospital
means a Hospital that has not entered into a written agreement with Us to provide health care services insured under a Medicare SELECT policy.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Restricted Network Provision
is any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

Service Area
is the geographic area approved by a State's Insurance Commissioner within which: (1) We are authorized to offer a Medicare SELECT policy; and (2) Network Hospitals are available.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

Traveling
means leaving the Service Area for purposes other than to receive services from a non-Network Hospital.

We, **Us**, and **Our**
refers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

NETWORK HOSPITAL RESTRICTIONS

Except as specified below, Part A and Part B (Hospital and Facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital and facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;
2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;
3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or
4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Us and has been designated by Us to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Our Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Our Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. (Travel must be for purposes other than the receipt of medical care.)

PLAN BENEFITS

We will pay as follows, subject to the Network Hospital Restrictions:

1. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;
2. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

4. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Section #10 below;
5. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Section #10 below;
6. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Section #10 below;
7. Coverage for fifty percent (50%) under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Section #10 below;
8. Except for coverage provided in Section #9 below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Section #10 below;
9. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
10. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

Expenses incurred when using out of network providers do no count toward the out-of-pocket annual limit described herein. See Network Restrictions section of this policy.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

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You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, We will provide a status update to You every ten (10) business days.

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In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P. O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be made within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 W. 3rd St., Little Rock, AR 72201-1904 or call 1-800-224-6330].

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND: Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to Us.

CHANGES IN MEDICARE COST SHARING AMOUNTS
If Medicare changes its deductible and coinsurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES
This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. Your Network Hospitals will bill us directly. When You use a non-Network Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

NOTICE OF CLAIM-TIME LIMIT
Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

CLAIM FORMS
When We receive notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notify Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:

1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions on Page 6 of this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

MEDICARE SELECT SUPPLEMENT PLAN N

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION
Please read the copy of the application which is a part of this policy. Check to see that all medical history requested is listed. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

We, STERLING LIFE INSURANCE COMPANY**,** promise to pay You, the insured/policyholder, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions. We have issued this policy in consideration of the payment of the first premium and the statements made in Your application.

RENEWAL CONDITIONS

You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time.

RENEWAL PREMIUM

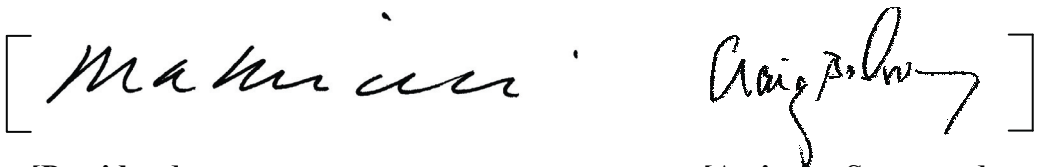
We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within thirty (30) days after You receive it. You may return it to Us by mail or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY CAREFULLY
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

Signed by Our [President] and [Assistant Secretary].



[President] **[Assistant Secretary]**

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.
Both Part A and Part B (Hospital and Facility) benefits described in this policy are restricted if You receive services in a Hospital that is not a Network Hospital. THIS POLICY IS RENEWABLE FOR LIFE. Premium Rates are expected to increase each year.

You can convert this policy to a policy which does not contain restricted network provisions. See Conversion Privilege.

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P. O. Box 5348]
[Bellingham, WA 98227-5348]
[(800) 688-0010]

TABLE OF CONTENTS

ELIGIBILITY AND EFFECTIVE DATE

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under this policy, You must be:

1. Eligible for Medicare;
2. Enrolled in both Medicare Parts A and B; and
3. A resident in an approved Medicare SELECT Service Area.

EFFECTIVE DATE OF INSURANCE

The effective date of insurance for You shall be: «effective_date»

POLICYHOLDER INFORMATION

Policyholder:	«first_name» «last_name»
Policy Number:	«policy_id»
Initial Premium Mode:	«cycle_code»
Initial Premium Amount:	«initial_prem»

DEFINITIONS

Benefit Period
is the time used to measure in-Hospital benefits for expenses covered by Medicare. It begins after the effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Calendar Year
is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

Complaint
is any dissatisfaction expressed by an individual concerning a Medicare SELECT Issuer or a Network Hospital.

Emergency Care
means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Grievance
is a dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy with the administration, claims practices, or provision of services concerning a Medicare SELECT Issuer or a Network Hospital.

Hospice
You must meet Medicare's requirement, including a doctor's certification of terminal illness.

Hospital
means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Injury
means bodily injury to You caused by an accident which results in a loss covered by this policy. The loss must begin while the policy is in force.

Inpatient Lifetime Reserve Days
means the additional non-renewable sixty (60) days of hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare
means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses
means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare SELECT Issuer
as referred to in this policy, means Sterling Life Insurance Company.

Medicare SELECT Policy
means a Medicare supplement policy that contains restricted network provisions (such as this).

Network Hospital
means a Hospital which has entered into an agreement with Us to provide health care services insured under this policy.

Non-Network Hospital
means a Hospital that has not entered into a written agreement with Us to provide health care services insured under a Medicare SELECT policy.

Physician
means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise are not covered by this Policy. "Physician" does not include You or Your immediate family members.

Provider
is the general term We use for Physicians, hospitals and health care facilities that are licensed by the state to deliver or furnish healthcare services.

Restricted Network Provision
is any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

Service Area
is the geographic area approved by a State's Insurance Commissioner within which: (1) We are authorized to offer a Medicare SELECT policy; and (2) Network Hospitals are available.

Sickness
means illness or disease which results in loss covered by this policy. The loss must begin while the policy is in force.

Skilled Nursing Facility
means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled
means Your total inability or incapacity, as a result of injury or sickness, to which extent You are no longer physically or mentally capable of managing Your affairs and lack a third party with authority to act on your behalf.

Traveling
means leaving the Service Area for purposes other than to receive services from a non-Network Hospital.

We, **Us**, and **Our**
refers to Sterling Life Insurance Company.

You, **Your**, and **Yours**
refers to the Policyholder referred to on Page 3.

NETWORK HOSPITAL RESTRICTIONS

Except as specified below, Part A and Part B (Hospital and Facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital and facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;
2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen Illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;
3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or
4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Us and has been designated by Us to provide hospital services insured under this policy. You may use any Network Hospital which is listed on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday].

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Our Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Our Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. (Travel must be for purposes other than the receipt of medical care.)

PLAN BENEFITS

We will pay as follows:

1. Coverage of the Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept Our payment as payment in full and may not bill You for any balance.
4. Coverage under Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed read blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the Medicare Part B coinsurance of Medicare eligible expenses regardless of hospital confinement, other than a co-payment of up to $20 per office visit and up to $50 per emergency room visit, subject to the Medicare Part B deductible. The co-payment is waived if the policyholder is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
7. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
8. Coverage for Medicare eligible expenses up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for skilled nursing facility care.
9. Coverage, to the extent not covered by Medicare, for eighty percent (80%) of the billed charges for Medicare eligible expenses of medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which is begun during the first sixty (60) consecutive days of a trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

The Part A deductible amount, co-payment amounts, and Part B Calendar Year deductible are determined by Medicare.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE

Complaints While Staying At A Network Hospital

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday], to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between [5PM and 5AM], weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, We will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P. O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state: "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be made within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 W. 3rd St., Little Rock, AR 72201-1904 or call 1-800-224-6330].

UNIFORM PROVISIONS

UNEARNED PREMIUM REFUND: Upon the death of the insured, any unearned premiums paid for any period beyond the end of the policy month in which the death occurred shall be refunded and paid to Your estate or Your beneficiary in lump sum on a date no later than thirty (30) days after the proof of death has been furnished to Us.

CHANGES IN MEDICARE COST SHARING AMOUNTS

If Medicare changes its deductible and coinsurance amounts, Your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give You appropriate notice of such change.

ENTIRE CONTRACT: CHANGES

This policy, with the attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Effective Date of this policy, only fraudulent misstatements on Your application may be used to void this policy or deny any claim for loss incurred or disability that starts after the two (2) year period. No claim for loss incurred after the Effective Date of coverage shall be reduced or denied on the ground that a medical condition had existed before the Effective Date of coverage.

GRACE PERIOD
This policy has a thirty-one (31) day grace period. This means that if a premium is not paid on or before its due date, it may be paid during the thirty-one (31) days that follow. During the grace period this policy will stay in force.

REINSTATEMENT
If the premium is not paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement and loss due to Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM
Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at Our Administrative Office address shown on Page 1. Notice should include Your name and the policy number.

We will accept notice from a Medicare Part B carrier on claims submitted on Your behalf by physicians and suppliers or You may submit the Explanation of Medicare Benefits (EOMB). If You are traveling outside Your home state, You should submit to Us a copy of Your EOMB. Your Network Hospitals will bill us directly. When You use a non-Network Hospital, they may submit Your claim for You, or You may have to submit the EOMB when You receive it. Notice of claims should include Your name and policy number.

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Except in the absence of legal capacity, written notice of claim must be received by Us within fifteen (15) months from the time Medicare has determined the eligibility of the claim. If notice is not given in time, the claims may be reduced or denied. The notice can be given to Us at Our Administrative Office. The notice should contain Your name and policy number.

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When We receive notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

PROOFS OF LOSS
If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within ninety (90) days after the end of each period for which We are liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed when reasonably possible. In any event, the proof required must be given within one (1) year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS

Benefits payable under this policy will be paid within fifteen (15) business days of when We receive proper written proof of loss. We shall have fifteen (15) business days within which to mail a letter of notice giving the reasons We have for not paying the claims, either in whole or in part. Such notice can be used to itemize any information needed to process the claim or any portions not being paid. After We have received all information needed to process the claim, We then have fifteen (15) business days to either pay or deny a claim giving You written notice of such action.

PAYMENT OF CLAIMS
All benefits will be paid to You or, if dually assigned, to the Provider. Any unassigned benefits due and unpaid at Your death may be paid, at Our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who cannot give valid release, We may pay up to $1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY
Sterling at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

SUBROGATION RIGHTS
The benefits of this policy will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this policy for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to us to the extent of all payment made by Us for such benefits. You or Your representative agree to cooperate fully with us to secure these rights of subrogation; and to otherwise help us recover benefits we have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

LEGAL ACTION
No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER INSURANCE WITH US
You may have only one policy like this one with Us. If through error, We issue more than one like policy to You, only one policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We will return the money You paid for the other policies.

CONFORMITY WITH STATE STATUTES
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

SUSPENSION AVAILABLE DURING MEDICAID ELIGIBILITY
If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of eligibility for Medicaid. Any refund will be subject to adjustment for paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then effective the date Medicaid entitlement terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

SUSPENSION AVAILABLE DURING COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN
If You are eligible for Medicare by reason of disability and become covered under an Employer Group Health Plan and, within ninety (90) days after the inception of such coverage, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Employer Group Health Plan coverage.

Suspension of policy benefits and premiums will begin from the effective date of Your Employer Group Health Plan coverage. When We get the timely notice, to the extent permitted by applicable law or regulation, We will refund any premium paid covering a period beyond the date of Employer Group Health Plan coverage. Any refund will be subject to adjustment for paid claims.

If You lose coverage under the Employer Group Health Plan during the suspension period and notify Us within ninety (90) days, then effective the date coverage terminated, We will: (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; (b) waive any waiting periods with respect to treatment of pre-existing conditions; and (c) charge a premium at least as favorable as if coverage had not been suspended.

TERMINATION

Your insurance will terminate in the event:
1. You fail to pay the required premium within the time allowed to keep the coverage in force;
2. You cease to be eligible for this plan; or
3. We receive written notice that You wish to terminate Your coverage.

If termination is due to an event described in either item 2 or 3 above, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

Pending Claims
If We terminate coverage for You, it will not affect any pending claim.

A pending claim will include only those medical services and supplies rendered or furnished prior to the date coverage ends.

Extension Of Coverage
If Your coverage ends while You are totally disabled, coverage will be continued for the disabling condition until the earlier of the following dates:
1. The date You are no longer totally disabled; (**Benefit is conditioned upon the continuous total disability**) or
2. The date that You exhaust Your policy benefit or reach any coverage maximum or limit.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid.

We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions on Page 6 of this policy.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	01/04/2010

Comments:

Attachment:

AR FleschCert.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Application		

Comments:

Please find Application included on the Form Schedule Tab.

		Item Status:	**Status Date:**
Satisfied - Item:	Outline of Coverage		

Comments:

Please find the Outline of Coverage included on the Form Schedule tab.

Certificate of Readability

This will certify that the policy referenced below complies with the minimum standards in accordance with the State of Arkansas Insurance Law ACA 23-80-206. The test of the policy achieves a minimum score of forty (40) on the Flesch reading ease test. This policy is printed in not less that ten-point type and one point leaded. The arrangement and overall appearance of the policies give no undue prominence to any portion over another. A table of contents of the principal sections of the policy is provided with the policy.

Standard Medicare Supplement

AR STD A (05/10)
AR STD B (05/10)
AR STD C (05/10)
AR STD F (05/10)
AR STD G (05/10)
AR STD K (05/10)
AR STD N

Select Medicare Supplement

AR SEL A (05/10)
AR SEL B (05/10)
AR SEL C (05/10)
AR SEL F (05/10)
AR SEL G (05/10)
AR SEL K (05/10)
AR SEL N

Craig Bodway

Digitally signed by Craig Bodway
DN: cn=Craig Bodway, o=Sterling Life Insurance Company, ou=Assistan Secretary, Compliance and Regulatory Affairs, email=craig.bodway@sterlingplans.com, c=US
Date: 2009.11.16 13:34:28 -08'00'

Craig A. Bodway
Assistant Secretary
Sterling Life Insurance Company

SERFF Tracking Number:	*STLG-126337628*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*44114*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - MIPPA 2010 Ind. STD/SEL (ABCFGKN) - Form/Rate Filing*		
Project Name/Number:	*2010 MIPPA Form/Rate Refiling /*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/27/2009	Form	Medicare Supplement and Select Application	11/18/2009	APP 2010 - AR.pdf (Superceded)
10/27/2009	Form	Notice to Applicant Regarding Replacement	12/10/2009	NTA (Rev 09.09).pdf (Superceded)

Sterling Life Insurance Company
Application for Medicare Supplement Insurance

P.O. Box 5348 ~ Bellingham, WA 98227 ~ 800/688-0010

1. Applicant Information

Insured's Name (as it appears on Medicare Card) _____
LAST FIRST MI

Medicare ID # _____ Social Security # _____

☐ Yes, I am insured under Medicare Part A and B / Part B Effective Date _____

Physical Address _____ Phone Number _____

City _____ County _____ State _____ Zip _____

Mailing Address _____

City _____ County _____ State _____ Zip _____

Age (at Requested Effective Date) _____ Date of Birth ___ / ___ / ___ Gender ☐ M ☐ F

2. Requested Effective Date ___ / ___ / ___

3. Medicare Supplement Coverage Options

Standard: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan K ☐ Plan N

SELECT: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan K ☐ Plan N

4. Payment Options

Monthly: ☐ Coupons ☐ Automatic Bank Draft

Statement: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Premium Amount Collected

$_____

5. Power of Attorney/Guardian

Have you authorized any person to legally act on your behalf and take over your personal business transactions (POA, Guardian, etc.)? ☐ Yes ☐ No

If Yes, Name (Please include documentation) _____

Address _____ City _____ State _____ Zip _____

Should all mailings go to POA, Guardian, etc. at this address? ☐ Yes ☐ No

IF YOU LOST OR ARE LOSING OTHER HEALTH INSURANCE COVERAGE AND RECEIVED A NOTICE FROM YOUR PRIOR INSURER SAYING YOU WERE ELIGIBLE FOR GUARANTEED ISSUE OF A MEDICARE SUPPLEMENT INSURANCE POLICY, OR THAT YOU HAD CERTAIN RIGHTS TO BUY SUCH A POLICY, YOU MAY BE GUARANTEED ACCEPTANCE IN ONE OR MORE OF OUR MEDICARE SUPPLEMENT PLANS. PLEASE INCLUDE A COPY OF THE NOTICE FROM YOUR PRIOR INSURER WITH YOUR APPLICATION.

PLEASE ANSWER ALL QUESTIONS. To the best of your knowledge:

6. (a) Did you turn age 65 in the last 6 months?: ☐ Yes ☐ No

(b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

(c) If yes, what is the effective date of Part B? ____/___/_____

7. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.

If Yes,

(a) Will Medicaid pay your premium for this Medicare supplement policy? ☐ Yes ☐ No

(b) Do you received any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

8. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END___/___/____

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No

(c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

(d) Did you cancel a Medicare supplement policy prior to enrolling in this Medicare plan? ☐ Yes ☐ No

9. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

(b) If so, with what company, and what plan do you have? _____

(c) If so, so you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

10. Have you had any coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)?) ☐ Yes ☐ No

(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START ___/__/___ END ___/__/_____

I UNDERSTAND IT IS MY OBLIGATION AND RESPONSIBILITY TO DISENROLL MYSELF FROM MY PRESENT MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE PROGRAM. NEITHER THE AGENT NOR THE INSURANCE COMPANY HAS THE AUTHORITY TO DISENROLL ME FROM THE PROGRAM.

Applicant's Signature _____

****If you are applying during an open enrollment or guaranteed issue period, you do not have to answer Health Questions 11 or 12.**

11. If any of the following questions are answered "Yes" the applicant is uninsurable.

A. Within the past two years, have you received any medical advice or treatment by a member of the medical profession, or been hospitalized for any of the following:

1. Stroke, heart attack, coronary artery disease including angina, arteriosclerosis or artherosclerosis or congestive heart failure? ☐ Yes ☐ No
2. Cancer (excluding skin), Leukemia, Hodgkins' Disease or Melanoma? ☐ Yes ☐ No
3. Alzheimer's Disease, Parkinson's Disease, Lou Gehrig's Disease or ALS, Multiple Sclerosis or Muscular Dystrophy? ☐ Yes ☐ No
4. Chronic Obstructive Lung / Pulmonary Disease or Emphysema? ☐ Yes ☐ No
5. Alcoholism, Drug Addiction, Cirrhosis of the Liver or Renal Failure? ☐ Yes ☐ No
6. Insulin Dependent Diabetes or Rheumatoid or Disabling Arthritis? ☐ Yes ☐ No
7. Have you required oxygen therapy, kidney dialysis, a defibrillator, bypass surgery, angioplasty, pacemaker or stent placement? ☐ Yes ☐ No

B. Have you been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV virus? ☐ Yes ☐ No

12. Within the past two years, have you been confined to or utilized: a hospital, skilled nursing facility, nursing home, ambulatory surgery center or another similar facility?

If "Yes", please explain below: ☐ Yes ☐ No

Condition	Onset Date	Operation Date	Recovery Date	Days in Hospital	Days in Nursing Facility

A. Please indicate your height and weight: _____ Ft. _____ In. / _____ Lbs.

B. Have you used tobacco products in the last two years? ☐ Yes ☐ No

13. Acknowledgments. The Applicant, to the best of his / her knowledge and belief, represents and agrees as follows:

A. You do not need more than one Medicare Supplement Policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

B. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy

C. If, after purchasing this policy, you become eligible for Medicaid, benefits and premiums under the Medicare Supplement policy will be suspended during entitlement to benefits under Medicaid for 24 months, as long as suspension is requested within 90 days of becoming eligible for Medicaid. When you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.

D. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while your are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

E. Counseling services may be available in your state to provide advice concerning the purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

F. That the statements contained in the application concerning past and present health conditions are complete, true and correct.

G. No agent or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.

H. Insurance issued as a result of this application will take effect as specified in the Conditional Receipt.

I. Plan provisions concerning exceptions, exclusions, limitations and renewal which have been applied for have been explained and understood.

J. The Applicant acknowledges receipt of the **Outline of Coverage** and the **Guide to Health Insurance for People with Medicare.**

14. Representation. The undersigned applicant and agent acknowledge that the applicant has read or has had read to him / her the completed application and that he / she realizes that any false statements or misrepresentation therein may result in loss of coverage under the policy.

15. **Payment of Premium**. Read the Conditional Receipt before signing this Application. This is to acknowledge that I have read the Receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of the Conditional Receipt.

16. **Release**. In connection with an application for insurance currently made to Sterling, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization shall be valid for a period of two years and six months from the date signed.

17. **Release for claims processing**. I further authorize Sterling, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Centers for Medicare and Medicaid Services (CMS), or its duly appointed Part A intermediaries or Part B carriers to release to Sterling information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include EOMBs, "deduct-not-met" or denial letter, Part B billing forms, and information date of enrollment in Part B of Medicare. I further authorize ongoing release of this information to Sterling for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Sterling in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, that I will need to fill out claims forms and some records could be released before the rescission has time to take effect.

Dated at City _____ State _____ Zip _____

Applicant's Signature _____ Date _____

Agent: List all policies you have sold to the applicant, including those no longer in force, if sold in the last five years (if none, state "none"):

Policies sold which are still in force: _____

_____

Policies sold in the past five years which are no longer in force:_____

_____

Agent Witness. I have witnessed the signature of the Applicant. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for ☐ is or is likely; ☐ is not or is not likely to replace or change any existing policy (ies) or contract(s).

Signature of Licensed Agent _____ Agent # _____

Print Name _____ Office ID _____

NOTICE. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate State Agency.

For Administrative Purposes Only:

STERLING LIFE INSURANCE COMPANY
Medicare Supplement Administrative Offices/Customer Service
[P.O. Box 5348 Bellingham, WA 98227-5348]
[1-800-688-0010]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Sterling. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:
I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s): (Check one):

- ☐ Additional benefits.
- ☐ No change in benefits but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ Other, please specify: _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
(Signature of Agent, Broker or Other Representative) (Date)

_____
(Typed name and address of Issuer, Agent or Broker)

_____ _____
(Applicant's Signature) (Date)